

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Proposing rule making related to medical and remedial services and providing an opportunity for public comment

The Human Services Department hereby proposes to amend Chapter 78, “Amount, Duration and Scope of Medical and Remedial Services,” and Chapter 79, “Other Policies Relating to Providers of Medical and Remedial Care,” Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is proposed under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

This proposed rule making updates and clarifies language to reflect existing prescribed outpatient drug policies for qualified prescribers, reasons for nonpayments of drugs, covered nonprescription drugs, quantity prescribed, drug reimbursement methodology (including dispensing fee limitation) and credits for returned unit dose drugs not consumed. This rule making also adds language regarding initiation of refill requirements with the prohibition of automatic refills without the member’s consent and includes legislatively required prior authorization (PA) limitations on medication-assisted treatment (MAT), including opioid overdose treatment, under the pharmacy and medical benefits.

Fiscal Impact

Removal of clinical PA for MAT drugs is projected to have the following impacts:

- For the pharmacy benefit: It is estimated removing the PA requirement would result in additional expenditures for this category of drugs. There would be increased prescribing/utilization.
- Pharmacy benefit increased expenditures are estimated at the following: Total dollars before rebates \$80,000 (\$24,000 state share); \$35,000 net of rebates (\$10,500 state share). The state share is based on a blend between the traditional Medicaid and Iowa Health and Wellness Plan populations. This fiscal impact is a combined total for both fee-for-service (FFS) and managed care programs.
- There are no associated programming costs with this change.
- For the medical benefit: There is no fiscal impact as none of these drugs require a PA under the medical benefit.
- Medical contracts: No impact projected to the Medical Contracts General Fund Appropriation.

Enforcement of the dispensing fee allowance on maintenance drugs is projected to have the following impacts:

- Clarifying the quantity prescribed and dispensing fee allowance could result in savings to the Medicaid program in cases where a pharmacy has been reimbursed greater than one dispensing fee per drug per member per month for maintenance drugs.
- The annualized savings is projected to be as follows per program based on the current dispensing fee of \$10.07 and current utilization:
 - FFS \$31,418 total (state and federal) dollars (based on April 2019 data and annualized).
 - Amerigroup \$336,000 (based on April 2019 data and annualized).
 - UnitedHealthcare \$660,965 (based on March 2019 data and annualized).

For both changes, PA removal and limit of one dispensing fee, the managed care organization (MCO) cost impact is part of the capitation rate setting.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Public Comment

Any interested person may submit written comments concerning this proposed rule making. Written comments in response to this rule making must be received by the Department no later than 4:30 p.m. on December 10, 2019. Comments should be directed to:

Nancy Freudenberg
Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114
Email: appeals@dhs.state.ia.us

Public Hearing

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)“b,” an oral presentation regarding this rule making may be demanded by 25 interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its [regular monthly meeting](#) or at a special meeting. The Committee’s meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions are proposed:

ITEM 1. Amend subrule 78.1(18) as follows:

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross reference ~~78.28(3)~~ 78.28(4))

ITEM 2. Adopt the following **new** subrule 78.1(25):

78.1(25) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

ITEM 3. Amend subrules 78.2(1) to 78.2(6) as follows:

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (~~physician, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner~~). Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

78.2(2) and 78.2(3) No change.

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A ~~as amended by 2010 Iowa Acts, Senate File 2088, section 347.~~

(1) to (3) No change.

(4) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

b. Payment is not made for:

(1) to (7) No change.

(8) ~~Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).~~

(9) to (12) No change.

(13) Drug products administered in a practitioner's office, outpatient clinic or infusion center.

78.2(5) *Nonprescription drugs.*

a. The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg

Acetaminophen elixir 160 mg/5 ml

Acetaminophen solution 100 mg/ml

Acetaminophen suppositories 120 mg

Artificial tears ophthalmic solution

Artificial tears ophthalmic ointment

Aspirin tablets 81 mg, chewable

Aspirin tablets 81 mg, 325 mg, and 650 mg, ~~81 mg (chewable)~~ oral

Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg

Aspirin tablets, buffered 325 mg

Bacitracin ointment 500 units/gm

Benzoyl peroxide 5%, gel, lotion

Benzoyl peroxide 10%, gel, lotion

~~Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg~~

~~Calcium carbonate suspension 1250 mg/5 ml~~

~~Calcium carbonate tablets 600 mg~~

~~Calcium carbonate vitamin D tablets 500 mg-200 units~~

~~Calcium carbonate vitamin D tablets 600 mg-200 units~~

~~Calcium citrate tablets 950 mg (200 mg elemental calcium)~~

~~Calcium gluconate tablets 650 mg~~

~~Calcium lactate tablets 650 mg~~

Cetirizine hydrochloride liquid 1 mg/ml

Cetirizine hydrochloride tablets 5 mg

Cetirizine hydrochloride tablets 10 mg

Chlorpheniramine maleate tablets 4 mg

Clotrimazole vaginal cream 1%

Diphenhydramine hydrochloride capsules 25 mg

Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml

Epinephrine racemic solution 2.25%

Ferrous sulfate solution 75 mg/0.6 ml (15 mg/0.6 ml elemental iron)

Ferrous sulfate tablets 325 mg

Ferrous sulfate elixir 220 mg/5 ml

Ferrous sulfate drops 75 mg/0.6 ml

Ferrous gluconate tablets 325 mg

Ferrous fumarate tablets 325 mg

Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid

Ibuprofen suspension 100 mg/5 ml

Ibuprofen tablets 200 mg
 Insulin
 Lactic acid (ammonium lactate) lotion 12%
 Levonorgestrel 1.5 mg
 Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride liquid 1 mg/7.5 ml
 Loperamide hydrochloride tablets 2 mg
 Loratadine syrup 5 mg/5 ml
 Loratadine tablets 10 mg
 Magnesium hydroxide suspension 400 mg/5 ml
~~Magnesium oxide capsule 140 mg (85 mg elemental magnesium)~~
~~Magnesium oxide tablets 400 mg~~
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
~~Multiple vitamin and mineral~~ Mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
~~Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg~~
 Nicotine gum 2 mg, 4 mg
 Nicotine lozenge 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin lotion 1%
 Polyethylene glycol 3350 powder
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pyrethrins-piperonyl butoxide liquid 0.33-4%
 Pyrethrins-piperonyl butoxide shampoo 0.3-3%
 Pyrethrins-piperonyl butoxide shampoo 0.33-4%
 Salicylic acid liquid 17%
 Senna tablets 187 mg
 Sennosides-docusate sodium tablets 8.6 mg-50 mg
 Sennosides syrup 8.8 mg/5 ml
 Sennosides tablets 8.6 mg
 Sodium bicarbonate tablets 325 mg
 Sodium bicarbonate tablets 650 mg
 Sodium chloride hypertonic ophthalmic ointment 5%
 Sodium chloride hypertonic ophthalmic solution 5%
 Tolnaftate 1% cream, solution, powder
Vitamins, single and multiple with prior authorization
 Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

b. No change.

78.2(6) *Quantity prescribed and dispensed.*

a. Quantity prescribed. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe ~~a quantity not less than a one-month supply of covered prescription and nonprescription medication sufficient for up to a 31-day supply.~~ Oral contraceptives Contraceptives may be prescribed in ~~90-day~~ three-month quantities.

b. ~~Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit dose system.~~

b. Prescription refills.

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are not allowed. A request specific to each medication is required.

2. All prescription refills shall be initiated by a request at the time of each fill by the prescriber, Medicaid member or person acting as an agent of the member, based on continued medical necessity.

ITEM 4. Amend rule 441—78.3(249A), introductory paragraph, as follows:

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross reference ~~78.28(5)~~ 78.28(6)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

ITEM 5. Amend subrule 78.3(18) as follows:

78.3(18) Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference ~~78.28(5)~~ 78.28(6))

ITEM 6. Amend subrule 78.4(4) as follows:

78.4(4) Periodontal services. Payment may be made for the following periodontal services:

a. No change.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference ~~78.28(2)“a”(1)~~ 78.28(3)“a”(1))

c. No change.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross reference ~~78.28(2)“a”(2)~~ 78.28(3)“a”(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference ~~78.28(2)“a”(3)~~ 78.28(3)“a”(3))

f. and g. No change.

ITEM 7. Amend subparagraph **78.4(5)“c”(2)** as follows:

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross reference ~~78.28(2)“c”~~ 78.28(3)“c”)

ITEM 8. Amend subrule 78.4(7) as follows:

78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

a. and b. No change.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and

a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross reference ~~78.28(2)“b”(1)~~ 78.28(3)“b”(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

(1) and (2) No change.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross reference ~~78.28(2)“b”(2)~~ 78.28(3)“b”(2))

e. to n. No change.

ITEM 9. Amend paragraph **78.4(8)“a”** as follows:

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference ~~78.28(2)“e”~~ 78.28(3)“c”)

ITEM 10. Amend subrule 78.6(4) as follows:

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. to d. No change.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross reference ~~78.28(3)~~ 78.28(4))

ITEM 11. Amend rule 441—78.7(249A), introductory paragraph, as follows:

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference ~~78.28(3)~~ 78.28(4))

ITEM 12. Amend subrule 78.9(10) as follows:

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. No change.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference ~~78.28(9)~~ 78.28(10))

ITEM 13. Amend subparagraph **78.10(3)“b”(10)** as follows:

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference ~~78.28(4)~~ 78.28(5))

ITEM 14. Amend subparagraphs **78.14(7)“d”(1)** and **(2)** as follows:

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference ~~78.28(4)“a”~~ 78.28(5)“a”)

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference ~~78.28(4)“b”~~ 78.28(5)“b”):

1. and 2. No change.

ITEM 15. Amend paragraph **78.26(4)“c”** as follows:

c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference ~~78.28(6)~~ 78.28(7))

ITEM 16. Renumber subrules **78.28(2)** to **78.28(11)** as **78.28(3)** to **78.28(12)**.

ITEM 17. Adopt the following **new** subrule 78.28(2):

78.28(2) Notwithstanding the provisions of 78.28(1)“a,” under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs:

- a. Buprenorphine,
- b. Buprenorphine and naloxone combination,
- c. Methadone,
- d. Naltrexone, and
- e. Naloxone for medication-assisted treatment, including an opioid overdose agent, as approved by the United States food and drug administration for treatment of substance use disorder and overdose treatment, will be available without prior authorization. For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

ITEM 18. Amend renumbered paragraphs **78.28(12)“a”** and **“b”** as follows:

a. Except as provided in paragraph ~~78.28(11)“b,”~~ 78.28(12)“b,” the following radiology procedures require prior approval:

(1) to (5) No change.

b. Notwithstanding paragraph ~~78.28(11)“a,”~~ 78.28(12)“a,” prior authorization is not required when any of the following applies:

(1) and (2) No change.

(3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member's receipt of such notice (see paragraph ~~78.28(11)“e”~~ 78.28(12)“e”); or

(4) No change.

ITEM 19. Amend paragraphs **79.1(8)“a”** to **“g”** as follows:

a. Except as provided below in paragraphs 79.1(8)“d” through “i,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“e.” 79.1(8)“c”;

2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“e.” 79.1(8)“c”;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)“c”; or

4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“e.” 79.1(8)“c”;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee;
or

3. Providers’ usual and customary charge to the general public.

b. No change.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers’ costs of dispensing drugs to Medicaid beneficiaries. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8)“a” above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The submitted 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

2. The average state AAC determined pursuant to paragraph 79.1(8)“b” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8)“a” because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)“a” above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost, (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(2) The average state AAC determined pursuant to paragraph 79.1(8) "b" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) "a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8) "a" above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR 447.508 will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(2) The average state AAC determined pursuant to paragraph 79.1(8) "b" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) "a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.